Olathe Public Schools
Secondary Health Intake Information

Today's Date: ____________ Grade: ____ Information obtained from: ____
Parent/Guardian

Student's Name: ____ Birth Date: ____________ Male ___ Female___
Last First MI

Physician: ____ Specialist/Other: _________________________

Preferred Hospital: ____

Current Medication / Treatment **Dose** **Time of Day** **Reason or Diagnosis**

___________________________ ________ _______________ _______________________________
___________________________ ________ _______________ _______________________________
___________________________ ________ _______________ _______________________________

Any development, behavioral, feeding, or swallowing concerns?

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Medical History

Please check **yes or no to all**, regarding student's medical history.

History	Yes	No	Comments	Medication
Vision correction Vision condition / loss			____Glasses ____Contact Lenses	
Ear Infections			____Currently ____Tubes (x_____)	
Hearing Loss			Type: Amplification Used: Cochlear Used:	
Headaches				
Seizures			Type of Seizure: Date of onset: Date of last Seizure:	
ADD or ADHD				
Mental / behavioral Concerns				

History	Yes	No	Comments	Medication
Dental Concerns				
Allergies			Food_______ Seasonal _______ Insect stings____ Medication_____ Reaction: Anaphylaxis:	
Asthma			List triggers	
Frequent Sinus Infections				
Bronchitis/Pneumonia				
Dizziness/Fainting Holds Breath				
Sleep Disturbances				
Tonsillitis (frequent)				
Nosebleeds			How often?	
Bladder/Kidney Concern				
Urinary Tract Infections				
Stomachache (frequent) Ulcers Irritable bowel			Specify:	
Cardiac/Heart Concerns				
Hospitalizations Surgeries			Age/year/reason:	
Accidents Head Injury/Concussion			Type of accident/age/year:	